CHESTER COUNTY OTOLARYNGOLOGY AND ALLERGY ASSOCIATES

A DIVISION OF PINNACLE EAR, NOSE AND THROAT ASSOCIATES

Adult and Pediatric Ear, Nose and Throat and Allergy Evaluation and Treatment

Andrew V. Chuma, MD	Head and Neck Cancer Surgery
Michael A. Hoffmann, MD	Thyroid & Parathyroid Surgery
Michael J. Ward, MD	Sinus Surgery
Timothy J. Downey, MD	Allergy Evaluation and Treatment
	Audiology and Hearing Aids

ALLERGY TESTING PACKET

Name: _____

Testing Date: _____

Test Review Date: _____

Included:

1) Please obtain the appropriate allergy testing referral from your primary care physician.
   a. AETNA - 99499 minimum 3 visits.
   b. Keystone - "Evaluate and Treat"
   c. CIGNA - Prescription from your primary care physician for "Allergy Testing and Treatment"

   Any questions regarding referrals, please contact the office.

2) List of medications which are not compatible with allergy skin testing. DO NOT STOP TAKING THESE MEDICATIONS but do let the doctor know if you are on these medications.

3) List of allergy medications to stop taking before allergy testing. **Non-compliance with testing protocol will require test cancellation**. The medications listed produce inaccurate results.

4) Allergy History Forms. **Please complete the history forms before you come in for your allergy testing.**

PLEASE bring completed allergy testing packet to your allergy testing appointment.

Please wear a loose/short sleeved shirt so we can access your arm for testing and please bring your asthma inhalers if you use them

*** These tests are scheduled for **1.5 hours** and are **scheduled weeks in advance**. We can typically only do 4-5 per day. When we get last minute cancellations, we can't just "fit people in" since most patients need to be off certain medications for a week before testing. If there is a chance you may not be able to make your testing appointment, PLEASE let us know ASAP so we can try to fill the spot. If we can't fill the spot, there may be a cancellation fee! ***

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Allergy Financial Consent/Disclosure Form

NAME: _____ DOB: _____ Date: _____

All Allergy patients are required to check the terms of their Insurance Contract regarding allergy treatment. You will find the phone number on the back of your Insurance Card.

Some Insurance Companies (eg: Aetna) do assign co-pays for allergy testing and injections. Please be aware that we are required to collect patient co-pays and deductibles at the time of service.

Codes to verify Coverage are as follows:

Testing codes: 95004 & 95024
Treatment Codes: 95165 & 95117

CANCELLATION POLICY: Due to the extended appointment time reserved for allergy testing, we must be notified within **3 business days** or a $50 cancellation fee may be charged.

Signed: _____ (Patient)

Relationship to patient (for minors): _____

Witness: _____

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Patients who are taking BETA-BLOCKERS (including eye drops) or TRICYCLIC ANTIDEPRESSANTS cannot get allergy skin testing.

They CAN get allergy blood testing (RAST). DO NOT STOP THESE MEDICATIONS UNLESS DIRECTED BY THE PRESCRIBING PHYSICIAN (Family doctor, cardiologist, psychiatrist etc). Below is a partial list of such medications:

BETA BLOCKERS:

Acebutolol	Corgard	Normozide
Akbeta	Corzide	Ocupres
Atenolol	Esmolol	Optipranolol
Betagan	Inderal	Penbutolol
Betapace	Inderal LA	Pindolol
Betaxolol	Inderide	Propranolol
Betimol	Innopran XL	Sectrol
Betoptic	Istalol	Sorine
Bisoprolol	Kerlone	Sotalol
Blocadren	Labetalol	Trandate
Brevibloc	Levatol	Tenoretic
Bystolic	Levobunolol	Tenormin
Carteolol	Lopressor	Timolol
Cartrol	Metipranolol	Toprol-XL
Carvedilol	Metoprolol	Timoptic
Chlorthalidone	Nadolol	Timoptic XE
Coreg	Nebivolol	Visken
Coreg CR	Normodyne	Zebeta

TRICYCLIC ANTIDEPRESSANTS:

Amitriptyline Hydrochloride	Imipramine Hydrochloride	Protriptyline
Amoxapine	Imipramine Pamoate	Sinequan
Anafranil	Limbitrol	Surmontil
Aventyl	Limbitrol DS	Tofranil
Chlordiazepoxide/Amitriptyline	Norpramin	Tofranil PM
Clomipramine Hydrochloride	Nortriptyline Hydrochloride	Trilafon
Desipramine Hydrochloride	Novo-pramine	Trimipramine
Doxepin Hydrochloride	Pamelor	Vicactil
Etrafon	Perphenazine/Amitriptyline	

460 Creamery Way, #103 Exton, PA 19341 610-384-8300	689 Unionville Rd. Kennett Square, PA 19348 610-345-0977	795 E. Marshall St.,# 303 West Chester, PA 19380 610-384-8300	213 Reeceville Rd, #10 Coatesville, PA 19380 610-384-8300	455 Woodview Road,# 210 West Grove, PA 19390 610-345-0977

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MEDICATIONS TO STOP BEFORE TESTING

The following medications must be stopped prior to allergy testing and can be stopped WITHOUT asking your doctor (it IS safe to stop these medications "cold-turkey).

Stop the following Antihistamines 1 week prior to testing:

Alavert
Allegra (Fexofenadine)
Allegra-D (Fexofenadine & Pseudoephedrine)
Atarax (Hyroxyzine HCL)
Benadryl
Cetrizine
Claritin (Loratidine)
Claritin-D
Clarinex
Clarinex-D
Diphenhydramine
Fexofenadine
Loratadine
Xyzal
Zyrtec
Tylenol PM
Exedrin PM
Any cough suppressants containing antihistamines

Stop the following (antihistamine sprays or drops) 3 days prior to testing:

Astelin (Azelastine)nasal spray
Astepro (Azelastine) nasal spray
Dymista (Azelastine Hydrochloride and Fluticasone Propionate) nasal spray
Patanase (Olopatadine Hydrochloride) nasal spray
Patanol (Olopatadine) eye drops
Optivar (Azelastine) eye drops
Zaditor (Ketotifen Fumarate) eye drops

PLEASE MAKE US AWARE OF ANY OTC MEDICATIONS YOU TAKE!

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Allergy Testing & Treatment Consent Form

NAME: _____ DOB: _____ Date: _____

I authorize the physicians and associated assistants of CCOAA to perform skin prick and intradermal skin testing upon myself / my child for the detection of possible allergies.
I further consent to the performance of such other or additional procedures different from that now contemplated, whether or not arising from presently foreseen conditions, which the above named doctors or their assistants may consider necessary or advisable in the course of the procedure. I have been made aware of certain risks and complications that are associated with the allergy testing procedure and allergy treatment. These include, but are not limited to hypotensive episodes (drop in blood pressure), worsening of allergic symptoms (runny nose, itchy eyes, hives) and in rare cases, anaphylactic reaction (severe allergic reaction) including possible death. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this procedure or treatment.

This document has been fully explained to me and I certify that I understand its contents and agree with the above.

Signed: _____ (Patient)

Relationship to patient (for minors): _____

Witness: _____

Informed Consent of Office Protocol

If I decide to initiate immunotherapy, I have been informed that I must wait up to 20 minutes in the office after each injection. This is for my protection. If an anaphylactic reaction should occur from an injection, it will usually happen within 20 minutes and can occur even though a person has been on the same treatment for years. I understand this and will not come in for an injection on a day when I cannot wait in the office for 20 minutes.

I have also been informed of my obligations with respect to referrals, co-payments and other insurance related issues for which I am responsible.

Signed: _____ _____

Patient (Or guardian) Witness